MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Outpatient Services • Chronic Dialysis Clinics

July 2007 • Bulletin 394

Contents

Providers Must Use New Claim Form

Medi-Cal implemented the use of the *UB-04* claim form on June 25, 2007. Providers who previously submitted claims on the *UB-92 Claim Form* must bill on the new *UB-04* claim form immediately. Providers not using the new *UB-04* should be in the process of transitioning. Failure to use the new form for claims submitted after June 25, 2007 may result in rejection of the provider's claim.

Submission instructions for *Claims Inquiry Forms* (CIFs) and *Appeal Forms* require a copy of the corrected original claim form be attached. Old *UB-92* claim forms will only be accepted for this reason.

2007 CPT-4/HCPCS Codes Reminder

Effective August 1, 2007, Medi-Cal will adopt the 2007 CPT-4 and HCPCS Level II codes. Claims billed for dates of service on or after August 1, 2007 must use the appropriate 2007 codes.

Codes to be added, modified or deleted were listed in the May 2007 *Medi-Cal Update*. Policy for new benefits was announced in the June 2007 *Medi-Cal Update*. Provider manual updates are included in this month's *Medi-Cal Update*.

Redirection of Treatment Authorization Request Services

Effective July 1, 2007, several regionalized *Treatment Authorization Request* (TAR) services provided by the Fresno Medi-Cal Field Office (FMCFO) were redirected to the Northern and Southern Pharmacy Sections (NPS and SPS), Sacramento Medi-Cal Field Office (SMCFO) and San Francisco Medi-Cal Field Office (SFMCFO).

This information is reflected on manual replacement pages tar field 1 thru 11 (Part 2).

Processing Changes for Treatment Authorization Requests

Beginning May 1, 2007, the California Department of Health Services (CDHS) started phasing in several changes that will impact how paper *Treatment Authorization Requests* (TARs) are processed.

These changes are being implemented to minimize the key data entry of incomplete or erroneous TAR information and to reduce the volume of paper documents containing Protected Health Information (PHI), particularly Social Security Numbers (SSNs) that are sent via:

- United States Postal Service
- Courier services
- Other types of delivery services

CDHS expects to complete this phased implementation by September 2007.

Please see **Processing Changes**, *page 2*

Processing Changes *(continued)*

Processing Change Schedule
Processing changes to paper TARs impact providers interacting with the Medi-Cal field offices and pharmacy sections on the following dates:

May 2007 Sacramento Medi-Cal Field Office	**August 2007** Fresno Medi-Cal Field Office San Bernardino Medi-Cal Field Office San Diego Medi-Cal Field Office San Francisco Medi-Cal Field Office
June 2007 Northern Pharmacy Section (Stockton) Southern Pharmacy Section (L.A.)	
July 2007 L.A. Medi-Cal Field Office In-Home Operations South	**September 2007** TAR Administrative Remedy Section In-Home Operations North

Incomplete TARs
CDHS Medi-Cal field offices and pharmacy sections will be unable to enter paper TARs with incomplete information into the TAR system. These paper TARs will be deferred back to the submitting provider, with a Medi-Cal field office/pharmacy section *Incomplete TAR Form* identifying the reasons for deferral and instructions about how to resubmit the paper TAR with the necessary corrections.

Providers are to:

- Make the necessary corrections/changes on the paper TAR, and
- Resubmit with a copy of the *Incomplete TAR Form* on top of the paper TAR.

Paper TARs that are returned to the submitting provider for correction will not be available for inquiry through the Provider Telecommunications Network (PTN).

Any one of the reasons below will not allow the paper TAR information to be entered into the system. The reason(s) will be marked on the *Incomplete TAR Form* and sent back to the submitting provider for corrections. These reasons may consist of one or more of the following:

- The TAR form is illegible or damaged.
- The submitting provider number is missing, inactive, suspended or invalid for the category of service requested.
- The patient's Medi-Cal ID number is missing, invalid or invalid in length, and the patient's name/date of birth is missing.
- The patient is not Medi-Cal eligible.
- Information in the *Admit From* field (Box 14) on the *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1) is missing or invalid.
- The requested service information is missing, invalid or invalid in length.
- The ICD-9-CM diagnosis code, admitting ICD-9-CM diagnosis code and/or primary DX diagnosis code is missing or invalid.
- The County Medical Services Program (CMSP) pharmacy services are covered by MEDIMPACT. Providers may call 1-800-788-2949 for further information.
- The requested Adult Day Health Care (ADHC) service should specify the months and the number of requested days for each calendar month on separate lines of the TAR. The TAR request should not exceed six months or have more than one service line for a given calendar month. Providers may refer to the appropriate Part 2 manual for specific TAR preparation instructions.

Please see **Processing Changes**, *page 3*

Processing Changes *(continued)*

Adjudication Response
CDHS will discontinue the practice of returning adjudicated paper TAR copies to providers based on the schedule above. Instead, providers will receive an *Adjudication Response* (AR), which will display:

- The status of requested service(s)
- The reason(s) for the decision(s), including TAR decisions resulting from an approved or modified appeal
- The adjudicator's request for additional information, if necessary

The AR will enable the provider to respond to the requested information or proceed to bill for authorized services. (See the *Adjudication Response* example at the end of this article.) Providers should keep a copy of the AR for their records and use it when responding to deferrals or when requesting an update/correction to a previously approved or modified TAR.

When requesting an update/correction, a copy of the AR must be placed on top of newly submitted documents to ensure the information can be matched with previously submitted documentation. Providers should clearly specify what change(s) are being requested.

The ARs will be mailed to the provider's address on file with CDHS' Payment Systems Division, Provider Enrollment Branch (PEB). Providers should ensure PEB has their most up-to-date mailing address on file. Instructions about changing/updating a provider address may be found on the Medi-Cal Web site (**www.medi-cal.ca.gov**). From the home page, click the "Provider Enrollment" link and then the "Provider Reminders" link at the top of the page.

Attachments
On November 15, 2006, CDHS notified providers via a flyer that attachments were no longer being returned with deferred paper TARs. Medi-Cal field offices and pharmacy sections will continue to retain and archive all attachments for reference.

Providers responding to a deferred TAR should return the AR and any new attachment(s) requested.

SSN on TARs
In accordance with *Medi-Cal Updates* issued in August and September 2006, providers should use the recipient's Benefits Identification Card (BIC) number on the TAR, rather than the SSN. If a TAR is returned to a provider because of inaccurate and/or incomplete information, the SSN will be removed.

Provider questions may be directed to the local Medi-Cal field office or pharmacy section.

National Provider Identifier (NPI) Number
Providers should be aware that the NPI number will not be accepted on TARs until after the official NPI implementation date of November 26, 2007. For detailed information about the new NPI implementation date, providers can view the "Important NPI Time Frame Changes" article posted in the "HIPAA News" area of the Medi-Cal Web site (**www.medi-cal.ca.gov**).

TARs issued under the old provider number (legacy number) prior to November 26, 2007 can still be used for claims submitted with an NPI starting on or after November 26, 2007. Providers will not have to request an updated TAR with the NPI information.

Please see **Processing Changes**, *page 4*

Processing Changes *(continued)*

State of California - Health and Human Services Agency
Department of Health Services

CONFIDENTIAL

Medi-Cal Operations Division

ARNOLD SCHWARZENEGGER, Governor

ADJUDICATION RESPONSE

Provider Number: HSCXXXXXX
XXX CONTRACT HOSP #2
3215 PROSPECT PARK DR
RNCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 06/27/2006
Regarding: Jane Doe
TAR Control Number: 9876543210

This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:

Svc #	Service Code	Modifier(s)	Service Description	From Date of Service	Thru Date of Service	Units	Quantity	Status	P.I.
1	123ABC	1	Service Description 1	01-01-2006	01-31-2006	12345	1000000.123	1 Approve	1
2	ABC123	2	Service Description 2	01-01-2006	01-31-2006	12345	1000000.123	2 Modify	0
	Reason(s):	GEN: Modified, refer to comments							
	Comment(s):	Comments from Field Office Consultant 2							
3	ABC123	3	Service Description 3	01-01-2006	01-31-2006	12345	1000000.123	3 Deny	3
	Reason(s):	GEN: Denied, refer to comments							
	Comment(s):	Comments from Field Office Consultant 3							
4	ABC123	4	Service Description 4	01-01-2006	01-31-2006	12345	1000000.123	4 Defer	5
	Reason(s):	GEN: Deferred, refer to comments							
	Comment(s):	Comments from Field Office Consultant 4							

Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.

If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.

TAR Requirement, Code Conversion for Botulinum Toxin Type A and B Injections

Effective for dates of service on or after August 1, 2007, botulinum toxin A (Botox®) will convert from local HCPCS code X7040 (10 units) to national HCPCS code J0585 (per 1 unit). Botulinum toxin B (Myobloc®) will convert from local HCPCS code X7042 (2,500 units) to national HCPCS code J0587 (100 units).

Botulinum toxin A and B are neuromuscular blocking agents used to treat various muscle disorders, and require a *Treatment Authorization Request* (TAR) for reimbursement. The TAR must have documentation justifying medical necessity including specific details regarding treatment, dosage and diagnosis.

Botulinum toxin A (Botox®) dosages are recommended up to 600 units in adults and 400 units in children. Botulinum toxin B (Myobloc®) is used in doses up to 25,000 units. However, higher dosages may be approved based on submitted TAR documentation supporting the medical necessity of the dosage used.

Please see **Botulinum**, *page 5*

Botulinum *(continued)*

If surgical CPT-4 codes are billed, providers should use modifier AG for the primary surgeon, and modifier ZM or ZN for the use of supplies or other drugs. When recipients require electromyography (EMG), endoscopy or anesthesia or sedation when receiving botulinum toxin A or B, those procedures may be reimbursed if billed on the same date of service as the drugs and accompanied by an approved TAR for J0585 and J0587. If two or more sites are injected on the same date of service, providers will bill for the total amount of botulinum toxin units injected.

Examples of conditions and diagnoses that result in muscle spasm that may benefit from treatment with botulinum toxin A or B are as follows:

- Cerebral palsy
- Multiple sclerosis
- Spinal cord injuries
- Cerebrovascular accident
- Spastic hemiplegia
- Blepharospasm
- Strabismus
- Torticollis
- Hemifacial spasm
- Spasmodic dysphonia
- Achalasia and cardiospasm *
  - * Achalasia and cardiospasm treatment with botulinum toxin A or B should be used only if the patient has failed conventional therapy, is at high risk of complications from pneumatic dilatation or surgical myotomy, or if previous procedures have failed or caused a perforation.
- Hyperhidrosis
- Frey's syndrome
- Detrusor hyperreflexia
- Detrusor sphincter dyssynergia
- Anal sphincter spasm
- Anal fissure

Non-medically necessary uses of botulinum toxin such as treatment of headaches, pain syndromes or cosmetic purposes (for example, facial wrinkles) are not reimbursable. In addition, claims for treatments that will not improve function, seem to be investigational, or are considered unsafe and ineffective will be denied.

Botulinum toxin A and B requests for children under 21 years of age require prior authorization by the California Children's Services (CCS) program.

This information is reflected on manual replacement pages inject 22 and 23 (Part 2) and inject list 3 (Part 2).

Diagnosis Restrictions for Gonadotropin Follicle Stimulating and Luteinizing Hormones

Effective for dates of service on or after August 1, 2007, CPT-4 codes 83001 (gonadotropin; follicle stimulating hormone [FSH]) and 83002 (…luteinizing hormone [LH]) are reimbursable only when billed in conjunction with one of the following ICD-9-CM diagnosis codes:

072.0	192.8	236.0 – 236.6	626.0 – 626.9
147.0	194.0 – 194.9	237.0 – 239.7	627.0 – 627.9
170.0	213.0	240.0 – 279.9	628.0 – 628.1
174.0 – 175.9	215.0	303.9	752.0 – 752.9
183.0 – 183.9	220	307.1	758.0 – 759.9
185	222.0	359.0 – 359.9	
186.0 – 186.6	225.0 – 225.9	456.4	
191.0	227.0 – 227.9	606.0 – 606.9	

Codes 83001 and 83002 should only be ordered when medically indicated, based on patient evaluation. Gonadotropin level tests for screening or non-indicated disease processes are not medically justified, and therefore not reimbursable.

ICD-9-CM codes 403.0 – 403.9, 404.0 – 404.9 and 571.0 – 571.9, that were previously supported in connection with codes 83001 and 83002, have been deleted.

This information is reflected on manual replacement page path chem 5 (Part 2).

Vaccine Billing Clarification

Providers are reminded to bill CPT-4 code 90471 (immunization administration; one vaccine) to Medi-Cal to be reimbursed for the administration of vaccines that are free to the provider through a source other than the Vaccines For Children (VFC) program.

When billing code 90471, providers must indicate the vaccine administered and its source in the *Remarks* field (Box 80) of the claim. Code 90471 may not be billed in conjunction with other vaccine injection codes (90281 – 90749 and X5300 – X7699) administered by the same provider, for the same recipient and date of service.

This information is reflected on manual replacement pages inject 1 and 2 (Part 2) and vaccine 1 and 4 (Part 2).

CCS Service Code Groupings (SCGs) Update

Effective for dates of service on or after August 1, 2007, a number of codes are end-dated and added to California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03, 04, 05, 06, 07, 10 and 12.

Reminder: SCG 02 includes all the codes in SCG 01; SCG 03 includes all the codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01. These same "rules" apply to end-dated codes.

The updated information is reflected on manual replacement pages cal child ser 1, 3 thru 16, 18 thru 20 and 22 thru 25 (Part 2).

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Remove and replace:	*Contents for Chronic Dialysis Billing and Policy* iii thru v * blood 1/2 * blood ub 3 thru 6 *
Remove: Insert:	cal child ser 1 thru 27 cal child ser 1 thru 26
Remove and replace:	cif co 7 thru 11
Remove: Insert:	cif sp op 1 thru 11 cif sp op 1 thru 8 *
Remove and replace:	hcpcs ii 1 thru 5 * inject 1/2, 5/6 *, 21 thru 24, 41 thru 44 *
Remove: Insert:	inject 59 thru 60 inject 59 thru 61 *
Remove:	inject drugs 1/2 *
Remove and replace:	inject list 1/2 *, 3/4, 5/6 *, 7/8, 9 thru 18 * inject vacc 1 * medi cr op pr 7/8 * medi non cpt 1 * medi non hcp 1/2 * modif app 5/6 *
Insert new section after the *Modifiers Used with Procedure Codes* section:	non inject 1/2 * (new)
Remove and replace:	path chem 5/6 tar field 1 thru 11 vaccine 1 thru 4